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EDITORIAL.

Far be it from us, members of a profession confessedly more than liberal in free giving to the deserving, to criticize any particular class of healthseekers, driven perforce to our climate, and still more severe would criticism be when its object is handicapped not only with a tedious if not incurable malady, but bears the additional load of financial anemia.

However severe such criticism might be considered, it, like many remedies, must be applied that good will result.

Leaving out of the question any theories as to the action of a climate on disease of the respiratory organs, there are certain economic and physical necessities which must be present and must be considered as part of the therapeutic treatment of all such cases.

We refer to the ordinary necessities

of life, the prosaic "board and lodging" which must be supplied as a foundation for other and it must be confessed, accessory treatment.

It seems almost puerile to call attention to a matter so common as this, but to one conversant with the records of any climatic resort it is notorious that a large majority of persons seeking relief take for their motto the old saying "take no thought of the morrow."

Healthseekers may rightly be divided into two classes: First, those able to provide themselves with the ordinary necessities of life; and second, those unable to make any such provision or having but a scanty or precarious income, try to eke it out by denying themselves of almost everything, and especially in the line of food and physical comforts.

With the first class, this article has nothing to do, nor with the first division of the second; these latter are to be treated as pure charity patients and cared for as far as municipal or state aid will permit.

The last division are the ones we need to help; need to advise, and need to warn before they start on their search for health.

Someone has defined poor people as coming under the head of "the Lord's poor; the Devil's poor, and the poor devils." All of us have seen examples of each, but this particular class are the "Lord's poor."

Honest and proud, too much so for their own good, they struggle at home against their malady, and finally buoyed up by a hope (ill-defined it may be) that relief will come quickly, scrape together their little belongings and find themselves in a strange land, where living is far higher and more uncertain, and where the purchasing power of a dollar has materially shrunk; too honest to beg, too proud to intimate their

actual necessities, their first move is to economize, and unfortunately nothing is left to retrench upon save food and heat, thereby sapping the very forces upon which they rely to gain strength, and when necessity finally leads to discovery of their wants, the damage has been too great to be counteracted, and another life has been added to the ever-increasing roll.

These are not isolated instances, but every practitioner will realize that hardly a day passes that he does not meet similar cases keeping up a brave front, but unable through lack of means, to make the sojourn necessary to rally the scattered forces of nature; the end is inevitable, either returning home impoverished to perish, a burden on friends or communities or a flickering out their last hours saddened by the additional weight of being what they so long dreaded, a pauper.

Aside from the sentimental view, the practical question is that these diseases can only be combated with any hope of success when the patient is mentally easy and ease of mind cannot exist with a scant purse or unpaid grocery bills.

To such an extent has been the influx of invalids with insufficient means that it becomes necessary to cry a halt, to utter a word of warning.

Actual living on the lowest basis consistent with lung trouble cannot be obtained in these western states at a lower rate than \$40.00 per month. Some set the figure higher, and even then this does not include any of the luxuries, but simply the essentials; therefore for anyone to change their residence unless prepared to meet this charge is suicidal and leads but to helpless invalidism or the final end.

Means should be taken to have all persons contemplating such changes for disease, aware of these facts, so that if unable to make the necessary arrange-

ments, they will not be left within a short time dependent upon the charity of others, far from familiar faces and surroundings, unable to return, but may meet the end, when such comes, among those who can and will care for them as only relatives and friends are able.

The annual meeting of the Territorial Association at Albuquerque, May 2, promises to be largely attended and most interesting. Many papers on up-to-date theories will be read, business of greatest importance will be transacted and much discussion enlivened. A committee appointed by the President of the Bernalillo County Society is at work and will leave nothing undone that may add to the success of the arrangements, and entertainment of unsurpassed qualities is guaranteed. Let us meet you all and unite for a season of pleasure and profit beginning Wednesday, May 2.

Believing that most of our readers are interested in Medical Reciprocity, two articles upon this subject appear in this issue. A careful perusal of each leads to the conclusion that there are still considerable differences between Dr. Harison and Dr. Webster, both of whom have given much thought and energy to a most practical plan for State Reciprocity on a fair, rational and equitable basis.

The Editor of the Ladies' Home Journal, with the aid of able legal talent, has gotten up a bill which he hopes to have introduced and passed in every State Legislature, regulating the sale of "Patent" and "Proprietary" medicines. Embodied in this bill are provisions compelling the makers of proprietary medicines to print upon their labels the composition and ingredients

of the article, and also fixing the retail price of the preparation according to the actual worth of the ingredients.

CHOREA.*

By G. W. Harrison, M. D.
Albuquerque.

Chorea is a neurosis. The term "Chorea Sancti Viti" or St. Vitus's dance, was first applied at Strasburg to the epidemic dancing mania prevalent in the fourteenth and fifteenth centuries, when the sufferers were taken, by order of the Strasburg magistrate, to the chapel of St. Vitus, to be cured by the influence of the saint.

This disease is characterized by irregular contractions of more or less of the voluntary muscles, giving rise to movements which are either involuntary or not under the direction of the will. The manifestations of the affection are first limited, usually, to a portion of the body, more often to one of the upper extremities, and in some cases the muscular contractions are confined to the fingers of one hand.

As a rule the movements increase and extend to the muscles of both upper extremities in a progressive manner, and to the face, and frequently to the lower extremities and to the trunk. The spectacle afforded by the manifestations of this affection is comical, and it is difficult (in the language of Flint) "to realize that it is not a performance for the amusement of observers." The condition, however, if the affection is severe, is truly distressing. The incessant muscular activity causes great fatigue.

The choreic manifestations are confined to the voluntary muscles.

The inability to direct and harmonize

voluntary movements is a prominent feature of this disease, and in this respect the affection is analogous to *progressive locomotor ataxia*. There is frequently *hemichorea*.

Hemi-chorea denotes a pathological condition which does not exist in the ordinary and general form of chorea. Long ago, J. Hughlings Jackson found on post mortem made on some of his cases, which had proved fatal, and some of which he reports had "one sided chorea," he reported that he found "embolic obstructions in the vessels of the brain."

Gower says, "As a rule, the nerve centres in chorea present no abnormal appearances, but in some cases alterations have been found, and are chiefly of two classes: (1) changes in the vessels, with or without secondary effects upon the brain, the result of either a morbid state of the blood or of local derangement of function; (2) alterations in the nerve-elements themselves, which are apparently primary, and the effect of the abnormal activity. In severe cases, of very acute course, general hyperaemia of the brain has been observed."

As to Etiology: The predisposing cause is a neuropathic condition of the nerve elements of the brain, particularly of the corpus straitum. The most frequent, and the most reliable exciting cause of Chorea, is emotion, and the particular form of the emotion is *fright*. Distressing pain may also be a cause. Among the exciting or determining causes are worms in the alimentary canal, and pregnancy. Rheumatism has long been regarded as a very important predisposing cause. Some authors have claimed that epilepsy, and ataxia were closely related to Chorea--the veteran Trousseau called them "The three sisters." Hereditary in-

*Read before the Bernalillo County Medical Society, at Albuquerque, Feb. 6, 1906.

fluences play an important part in the cause of this affection.

Chorea is essentially a disease of youth. Nine-tenths of the cases occur between the ages of 5 and 20, and four-fifths between 5 and 15.

The disease is occasionally met with after middle life, and even in extreme old age. Many cases of senile Chorea depend on a morbid process different in nature from that which causes the juvenile disease, although similar in effect. Chorea affects girls three times as frequently as boys. A combination of recorded statistics by the London Lancet in 1888 gives 365 boys to 1,000 girls. In the great majority of these girls the affection dated from the beginning of menstruation. And the age at which the greater portion became affected was 13.

The writer has had several cases in the past several years in which the disease was ushered in with the disturbances of beginning of the menstrual function, and the affection disappeared when normal menstruation was completely established. (Of course under proper treatment)!

The characteristic symptoms of Chorea, the spontaneous, inco-ordinate, irregular and recurring, the involuntary, muscular contractions are well marked in all severe cases, and mental failure is usually present in more or less degree. Sensibility is unaffected, as a rule.

Fortunately, Chorea is not a painful disease. The muscular spasms cause fatigue, but do not occasion any sensation of pain.

As a general thing this affection is not accompanied by any febrile movement, but in rare cases there is a rise of one or two degrees in temperature, if

more than that it would doubtless be from complications.

Anemia is an attendant on Chorea, and in some cases shares in the etiology of the disease. Sleep is much interfered with in severe cases.

The urine contains an excess of urea and of phosphates, but no albumen.

The peculiar pigment "urohematoporphyrin" has been found in both chorea and rheumatism, and this fact has been forcibly presented by McMunn and Garrod as establishing the intimate relation and connection between these two diseases. They claim this pigment is not found in any other nervous disease, but is rather constant in rheumatism.

The average duration of chorea is, say, three months. Some authors give it as from a few weeks to several months. Gowers puts it at from "six weeks to six months." A small proportion of cases become chronic.

This disease is prone to recur. As a rule the relapses are of shorter duration than the primary attacks. The cases developing in later life are much more apt to become chronic than those occurring in childhood.

In general, the prognosis is favorable. The average mortality is probably not over 2 per cent. The most fatal form is chorea gravidorum—20 to 25 per cent. Most of the fatal cases occur about puberty.

Some authors give a number of varieties of Chorea: Hereditary, Electrical, hysterical, senile, Pre-hemi-plegic, Post-hemiplegic, Gravidorum and Maniacal.

The Homeopaths claim they have a variety they call "Hunterian."

In the treatment of this unfortunate disease, the general laws of hygiene should of course be well attended to. The excretory organs must receive careful attention. The bowels must be

kept open. Do all possible to remove the cause.

Of the useful drugs, I would have arsenic head the list. Next in order, strychnia. Iron is often necessary, even in combination with the other remedies named. Other remedies highly thought of by some, are zinc, cannabis Indica, opium, cimicifuga, and various antispasmodics.

I favor Fowler's Sol. of Arsenic, commencing with three drops, after meals, three times a day, and then increase till the characteristic effects are produced. In very severe cases the hypodermic injection of Fowler's solution of arsenic, as per Hammond, is very effective, and very satisfactory.

OPERATIVE TREATMENT IN FRACTURE OF THE PATELLA.

By J. B. Cutter, M. D., Albuquerque, N. M.,
Surgeon to Santa Fe Coast Lines.

No procedure of which I know in the domain of acute surgery yields more gratifying results than the operative method of treatment for recent fracture of the patella.

The old expectant plan was tedious and debilitating to the patient, and the result uncertain and disappointing to the surgeon.

In the condition above spoken of we have present all the elements for the exercise of the highest standard of modern aseptic surgery which coupled with the perfection of mechanical skill bring about a state of physiological restoration, a result as nearly perfect as the high art of modern surgery is capable of.

In acute fracture of the patella especially those cases (the majority) accomplished by indirect violence, the trauma consists, not only in dissolution in continuity of bone, but a secondary pathological accident (the primary one calling for the interference of the sur-

geon) that of the interposition between the fresh surfaces of broken patella of fringes of the periosteum blood clots, etc., making repair by bony union a physical impossibility.

We may point out here the indication for surgical interference in fracture of the patella, and I say for a perfect repair the indication is absolute. Simply the removal of interposed tissue and blood clots from between the fragments of broken bone, in order that apposition of bone to bone may be accomplished.

The Operation—Many operations, bearing the names of their advocates have been put forth. The text books have been replete for years, and I do not deem it necessary to describe them at this time. In my opinion, the salient feature of the operation is accomplished in them all, namely, the cleansing of the joint of all interposing material, the further points of their operations I consider indifferent, and the method as in some of drilling and wiring the fragments unnecessary.

During upwards of two years' service at the old Chambers' Street Hospital in New York, now known as the Hudson Street Hospital, which is the House of Relief of the New York Hospital, I had the pleasure of assisting Dr. Louis A. Stimson in performing his operation for fracture of the patella many times, and I have since performed it on several occasions; the method deduced by Dr. Stimson, and known as "mediate ligation," I will describe as briefly as possible.

The technique of the operation which, while it must be absolutely perfect as to every step of asepsis (and without which assurance the operation is unjustifiable) is withal so simple that the operation may be done with local anesthesia.

It is advisable as a preliminary step when the patient is admitted to the hos-

pital to first cleanse the knee, envelope at once in fairly snug elastic bandage, then elevate and apply ice cap for 24 to 36 hours. By this means the great effusion of the joint which invariably follows the injury, is controlled.

The knee joint, then having been shaved, scrubbed and thoroughly prepared, a longitudinal incision is made from two to three inches long over the patella, the sides of the wound are retracted, and the broken bone is brought into view, the fringes of the torn periosteum are carefully lifted out and reflected backward with forceps and (I make a point of this) the fingers of the operator or assistants are at no time introduced into the field of operation. Blood clots are now removed, and the area gently flushed with a sterile normal salt solution, allowed to flow from its glass retainer: the limb being held now in full extension by an assistant the fractured patella fragments are easily apposed with anatomical precision and a few interrupted cat gut sutures through the periosteum will suffice to hold them; a heavy silk ligature is now passed through the quadriceps tendon down across the broken patella through the ligamentum-potellae, and firmly tied; this ligature will therefore twice cross the line of fracture and serves as well as relieving the strain on the broken bone produced by the powerful quadriceps through the patella to the patellar ligament, the equally important purpose of preventing the tilting upwards of the fragments to which there is a tendency.

Sometimes a purse string suture is introduced so as to surround the entire patella, but in most cases this step I consider as superfluous.

The skin wound is now closed with continuous cat gut suture, the knee enveloped in an ample sterile dry dressing, and a plaster of paris cast applied

from ankle to hip. This may be cut down and removed and the stitches taken out on the tenth day; the cast must however be worn continuously for five or six weeks, and in the day time as a support for a month longer.

At the end of three months union is not only firm, but the function of the joint has by this time been restored, while in all probability the patient treated by the old expectant plan is still in bed, the limb still harnessed to an inclined plane.

THE CLIMATIC TREATMENT OF PULMONARY TUBERCULOSIS.

By P. M. Steed.

Few subjects in all medicine have received such thorough study in our time as tuberculosis. Current methods in the treatment of its pulmonary form average better than those of old. Results prove this fact.

With the discovery of the bacillus tuberculosis by Koch in 1882, new interest was aroused in the study of phthisio-therapeutics. It was hoped and expected that the discovery of the cause of tuberculosis would quickly lead to the discovery of an antidote for this insidious micro organism which is destroying more than one hundred thousand of our citizens annually; but while a decade has passed, we are no nearer a specific than previous to the discovery of the cause of this disease. It is conceded by all authorities that four elements enter into the treatment of those afflicted with pulmonary tuberculosis, which are: First, increased nutrition; Second, rest of mind and body; Third, medical treatment and supervision; and Fourth, a continuous residence in the most favorable climate; the mode of life to be nearly continuous in the open air both day and night the year around.

The four features in the modern treatment of pulmonary tuberculosis

are of such equal importance that it is estimated that the chances of recovery are reduced 25 per cent for each that is omitted or neglected. In this paper we will consider the climatic treatment only. Climatic treatment of tuberculosis has rightly become popular the world over. Now, one of the first thoughts in behalf of a consumptive is to send him away for this climatic benefit. What climate is the best for pulmonary tuberculosis is answered by one of the highest authorities. For instance, that which has the least humidity, the least rainfall, the gentlest wind movement, the least difference between day and night temperature, and the highest per cent of sunshine, with an altitude that is adapted to each individual case. In considering climate, there is nothing so important as to consider the effect of altitude, and briefly it may be said that, the heart is the index—a rapid heart being invariably a contra-indication to an altitude that exceeds three thousand feet. So also in cases where the disease has reduced the respiratory surface, for dyspnoea will invariably follow residence in a high altitude. We do not claim that any air is in any sense a specific for pulmonary tuberculosis. The question is in what climate can the open air treatment be the most fully and beneficially carried out? As a rule it may be said the climate in which a person contracted the disease is the worst in which he can reside. It is well known that a cold and damp country invites tuberculosis, while a warm and dry, or a cold and dry atmosphere has a beneficial effect upon this morbid process. It must be apparent that the open air, or out of door life, is adapted for those sections where rain is infrequent and where high wind and cold weather do not occur. Unfortunately there is no one section where the ideal conditions

exist the year round. For this reason to get the best results out of climatic treatment one must have two homes; one in the lower altitude in winter and one in the higher section during the heated season. The curability of pulmonary tuberculosis is proved from two sources: First, the pathologists are constantly exhibiting lung specimens that show healed citatrices that were once the sites of tubercular activity. Bondet, of Paris, recently reported 138 autopsies of which 117 revealed healed tubercular sites, and the investigation of others show a similar high per cent. Second, from physicians in private practice and from sanitariums in every country come reports of cures, that is, a cessation of all pulmonary symptoms and a return to normal health.

It is a hopeful sign that the last decade has shown a decreased mortality of from about 14 per cent to 10½ per cent. Although this reduction may be more apparent than real. Many who are doomed to ultimately die of tuberculosis are prolonging their existence by modern phthisio-therapeutics, the most important of which is, the open air treatment in a climate that is suitable for this mode of life. The question of residence has been satisfactorily settled by the use of the canvass house, which is a tent built on a frame with a tight board floor with doors, windows, etc., which go with a comfortable residence. Thus arranged we have an abode that gives a constant interchange of air, but without draft. But it must be apparent that such an abode is only adapted to a dry climate where rains are infrequent and evaporation is rapid. I am opposed to housing a number of tubercular cases in one building, as they depress each other. The effect of constantly inhaling pure air is that of a constant antiseptic to the lungs of the most soothing and healing order. This

continuous ventilation of the lungs yields oxygen in abundance, which is taken up by the blood and carried to all parts of the body. An improved condition of the blood means a strengthened state of the nerve centers, which in turn means healthier and more vigorous nerve impulses to every function of the body. Especially is this shown upon the appetite, digestion and assimilation, which is the foundation upon which recovery is built. When the bacilli of tuberculosis become lodged in the tissues the irritation of their presence causes a deposit of leucocytes and connective tissue-cells in such a way that a small tumor is formed. This is a tubercle, the characteristics of which are, that it has no nerve blood or air supply. It is this knowledge that makes a specific cure for pulmonary tuberculosis so doubtful. How to reach the organisms that are incased in the tubercle is a question that seems to be without solution, except something that will produce immunity. There are two fates that may befall a tubercle; one is to soften and break down; this is an unfavorable course. The other is to harden or fibrose; this is the favorable and life-saving process of nature. So long as the bacilli of tuberculosis are present the disease usually runs a slow and chronic course; but in most cases other forms of germs gain entrance, the most common and pernicious being the streptococcus, and we then have a mixed infection; a condition that is certainly not receiving the attention its seriousness merits. It has been proved that in the presence of oxygen the toxins which cause fever with its resulting night sweats and emaciation are inhibited. The importance of being in a climate where one can live his life in the open air is too apparent to need further reference. It must be obvious that any obstruction to respiration is a

great injury to one who needs all the air that the lungs can breathe in.

HISTORY AND PHYSIOLOGY OF GENERAL ANESTHESIA.

Francis T. B. Fest, M. D., Las Vegas.

History.

The desire to avoid pain and to find the proper means to prevent same must be as old as the human race, yet it is less than a century that a general anesthesia, based upon scientific principles, has been revealed. Unknown as it was before, the knowledge of it is now so universal and the blessings which attend its use are so constant that we are sometimes apt to think so little of its existence and power as we do of the presence and power of light. It is impossible to estimate or form any adequate conception of the amount of human suffering which anesthesia has relieved and prevented. To this discovery the human race owes the blessing that no pain follows the course of the surgeon's knife into the living tissues, that the accoucher can alleviate the agonies of travail.

Such a power, which John Baptista Porta had strangely prophesied centuries ago, which mesmerism hinted at, which mystics now and then proclaimed, but which the world never dared fully to accept, has been partly acquired and which even now is very imperfect and the strife has not come to a desirable conclusion.

At a time when according to the mosaic mythology, Adam and Eve were enjoying their new discovery in the Far East, the cradle of our knowledge, the use of hashish was known. In Sanskrit, called "bhāṅg" and in Chinese "ma-yo."

The father of history, Herodotus, ascribes to the Scythians the use of a

*Paper read at the November meeting of the Las Vegas Medical Society—(Symposium on General Anesthesia.)

vapor of hempseed to produce a state of forgetfulness. Criminals, when condemned to the last, used "Eruca" not to feel the punishment. Hoa-Tho, 220 B. C., contributed to the immense Chinese literature a report about many operations done absolutely painlessly after the administration of a draught. It took sometimes several days before the patients recovered from the profound sleep, and I suppose some kept on eternally.

The Greek school used the so-called "Memphitic Stone," which imported from Egypt, was pulverized and dissolved in vinegar. Doubtless a compound of several narcotics.

Christian tradition tells us that the sufferings of the crucified were alleviated by inhalation from a sponge

In the year 79, Pliny says mandragora was used before "*cutting and puncturing*." Dioscorides gives an elaborate description of the proper preparation of mandragora; he uses the term anesthesia "polein anaesthesian," in relation with those being prepared to "*be cut, cauterized and saved*," Dodonius and Apulejus, one century later, speak of "*painless operations*"

Hugues de Lucques in the xii C. stupefied his patients by means of a sponge saturated with the juices of several solameae and resuscitated same afterwards by the fumes of vinegar.

1298 Theodoricus gave directions to prepare the "spongia somnifera" . . .

Boccaccio in his *Decamerone*, xxxix relates of his contemporary, the Surgeon Mazzeo della Montagna of Salerno, that he distilled a water to put to sleep his patients during operations.

1532, Canappe again describes the sponges of Theodoricus, and warns surgeons because they kill sometimes. Early in the xv C. in England, nerve-pressure on the neck was recommended. But this was due to ignor-

ance of the physiology of unconsciousness. Not by pressure of the nerves, but by compression of the carotida and the ensuing cerebral anemia is unconsciousness produced. A procedure which is known of old to the Malays and Hindu, especially the thugs, and was used at the beginning of last century in French hospitals.

1540, Valerius Cordus for the first times gives the instruction to still ether from equal parts of alcohol and sulphuric acid. He names same "oleum vitrioli dulce." He was well acquainted with its stupefying properties.

1730, Frobenius uses for the first time the term "ether."

1744, Hoffman publishes extensive studies of the properties of alcohol and ether.

1795, Pearson inhaled ether to facilitate a tooth extraction, but took not enough and lost all the glory.

At about this time in Paris patients were rendered unconscious by being placed on the floor and several men lifting him suddenly and producing thereby cerebral anemia.

1805, Nysten constructed an ether inhaler.

Sir Humphrey Davy discovered the properties of nitrous oxide and narcotised himself in 1818 and made the following statement which led to the real discovery of true surgical anesthesia. "As nitrous oxide in its extensive operation seems capable of destroying physical pain, it may properly be used with advantage during surgical operations."

1828, Girardin read a report to the Royal Academy of Medicine, how by the inhalation of different gases harmless anesthesia can be procured.

1832, Dauriol cites five cases of painless surgical operations by the use of the sponge of Theodoricus.

1839, Pereira in his famous work,

states that anesthesia can be produced by inhalations of ether as well as of nitrous oxide.

In 1842, Dr. Wilhite of Athens, Ga., in a frolic had rendered a young negro completely insensible by ether without any bad results. This circumstance excited Dr. Crawford W. Long to extirpate a tumor of the neck of one *Vine* under ether anesthesia, and repeated same anesthesia at operations during the years 1843 and 1844. Long did not publish his success, but when Morton and Jackson appeared on the scene, he made the patient give a sworn statement, July 1849. Dr. P. A. Wilhite assisted during the first operation, and communicated the fact, 1877, to Marion Sims, who at once published the facts.

Wells of Hartford, had knowledge that the Chemist Colton had put himself to sleep by nitrous oxide, and afterwards did the same with one Cooleg. Dec., '44, Wells had one tooth extracted, and waking up was so pleased that he prophesied: "*A new era in surgery! I have felt no more pain than from the pricking of a pin!*" And truly from that moment began the era of general anesthesia.

During the next two weeks he extracted fifteen teeth with nitrous oxide.

He went to Boston and communicated his discovery to his former pupils and friends Morton and Jackson and desired to give a public exhibit at the general hospital. They attempted to dissuade him, but nevertheless a trial was made with one Eben Frost. The man did struggle; some gas was lost, and the students cried "humbug," and Wells left Boston a disappointed, but not disheartened man. He kept up his experiments and changed to ether. He gave ether for Dr. Marcy for hydrocele, August 17, 1847, and for Dr. Heresford, January 1, 1847, for amputation of the mamma.

In the meantime, Morton and Jackson were not idle. Their master, Wells, had imparted to them his knowledge. They intended to steal his merit and turn the same into money. Sept. 2, '46, Morton extracted a tooth with what he called "letheon," a mixture of which he claimed to have discovered. They undertook to have their process of anesthesia patented, but failed as well here as in England, as no money was to be found. Soon the two began to quarrel for the honor. Their punishment followed; when Jackson had succeeded in establishing a fake claim of priority, Morton died of apoplexy, and when Jackson found himself dishonored, because Bigelow who saw Dr. Riggs pull the tooth of his friend, Wells, fought mercilessly for Wells, and the disappointment drove Jackson insane.

Independent from this, in Europe Simpson had experimented with acetone, nitrite of ethyl and benzene. Afterwards he used chloroform on fifty parturient women and published his results in 1849. From then the history is an endless report of the victory of chloroform as a favorite, and death after death follows, and in consequence one chemical after the other was used to replace chloroform.

1853 and 1854, Congress attempted to decide priority, but reached no understanding, and the well-worn hatchet was dug up year after year until the A. M. A. decided in favor of Wells.

1853, Snow published fifty-three cases of deaths from chloroform.

1859, The French Academy collected about 290 cases of deaths due to chloroform.

1863, Lallemand and Perrin began the research for the cause of death.

1865, Sabarth in Germany collects the reports of 119 deaths due to chloroform.

1866, Nothnagel makes a study of

fatty degeneration of the various organs with death due to chloroform. In the same year Senator in Vienna reports the findings of 46 cases of accidents due to chloroform.

1867, Reeve attempts to prove that about all these reports are erroneous. He seemed to have struck the favorite note and the death list increased in an unheard of manner.

1873, Gross declared himself in favor of ether as the safest. Eriehsen follows him.

In 1876, the Surgeon General of the Army started a chloroform investigation and publishes a history. Bigelow succeeds in establishing the priority of Wells in his address for "A Century of American Medicine."

1880, First British Chloroform Commission.

1880, First Hyderabad Commission. The number of deaths undoubtedly due to chloroform for the decade was given as 120. In the same year a motion was made before the A. M. A. to abolish the use of chloroform entirely as unethical.

1881, The Philadelphia Medical Times brings in an editorial statement. "He who still persists in the habitual employment of chloroform, seems to us beyond the reach of arguments of human speech!"

The second Hyderabad Commission published in their report of 1900 the dangers of chloroform as paralyzant of the respiratory centers, but all the sad experiences seem not to have been able to give ether the universal preference.

However, a new era seems to be beginning. There is nothing new under the sun, the oldtime monoragora must serve again, but this time through *its* *alcaloid hyposcine or scopolamine*. Many reports have been published about successful scopolamine anesthetics and the combination with chloroform or ether.

Even Las Vegas has taken part in this new beneficial movement, and to Dr. Black belongs the honor of having used it in mixed anesthesia for the first time.

I hope the Schneiderlin-Korff anesthesia which since 1898 found an increasing number of friends, proves to be what nearly all reports claim. A careful study of all literature at my disposal shows that the reason in contrast are those as a rule given by old fogies to all innovations, they do not know themselves, but condemn everything new, especially when it comes from across the ocean. Cocaine produced a large death list, but cocaine and allied drugs came to stay. Scopolamine-anesthesia is in its infancy—let us wait, try, strife and judge then.

In the search for an anesthetic which show less fatal results than chloroform, the following agents have been tried with varying results:

I Methyl group.

Methyl hydride, methane, $C H_4$.

Methyl chloride or monochloromethane, $C H_2 Cl_2$.

Dichloromethane, $C H_2 Cl_2$.

Chloroform or methenyl chloride, $C H Cl_3$.

Bromoform or methenyl bromide, $C H Br_3$.

Carbon tetrachloride or tetrachloromethane, $C Cl_4$.

II Ethyl group.

Ethyl hydride or ethane, $C_2 H_6$.

Ethylene, $C_2 H_4$.

Acetylene, $C_2 H_2$.

Ethyl chloride or chloroethane, $C_2 H_5 Cl$.

Ethyl bromide or bromoethane, $C_2 H_5 Br$.

Ethyl iodide or iodoethane, $C_2 H_5 I$.

Ethene chloride, $C_2 H_4 Cl_2$.

Ethidene chloride, $C_2 H_4 Cl_2$.

Ethylene bromide, $C_2 H_4 Br_2$.

Ethylene iodide, $C_2 H_4 I_2$.

Ethidene bromide, $C_2 H_4 Br_2$.

Trichlorethane, $C_2H_3Cl_3$.

Ethenyl chloride, $C_2H_2Cl_2$.

Trichloraldehyde, C_2HCl_3O .

Bromalhydrate, C_2HBr_3O .

Trijodaldehyde, C_2HI_2O .

Tetrachlorethane, C_2Cl_4 .

Hexchlorethane, C_2Cl_6 .

Ethyl ether, $C_4H_{10}O$.

Ethyl aldehyde, C_2H_4O .

Propyl group.

Trichlorhydrin or allyltrichloride, $C_3H_5Cl_3$.

Dichlorhydrin or glyceryloxychloride, $C_3H_5HOCl_2$.

Acetone or methylacetyl, C_3H_6O .

Butyl group.

Butylhydride or diethyl, C_4H_{10} .

Butylchloral or trichlorbutylaldehyde, $C_4H_5Cl_3O$.

Amyl group.

Amyl hydride or isopentane, C_5H_{10} .

Amylene or isopentene, C_5H_{10} .

Amyl chloride, $C_5H_{11}Cl$.

Amyl iodide, $C_5H_{11}I$.

Amyc alcohol, $C_5H_{12}O$.

Amylaldehyde, $C_5H_{10}O$.

Capryl hydride or Hexane, C_6H_{14} .

Ethyl formate, $C_2H_5CH_2O_2$.

Methyl acetate, $C_2H_5C_2H_3O_2$.

Propyl acetate, $C_3H_7C_2H_3O_2$.

Butyl acetate, $C_4H_9C_2H_3O_2$.

Amyl acetate, $C_5H_{11}C_2H_3O_2$.

Ethyl nitrate, $C_2H_5NO_3$.

Aromatic group.

Benzol or phenylhydride, C_6H_6 .

Terpene, $C_{10}H_{16}$.

PHYSIOLOGY OF GENERAL ANESTHESIA.

The problems connected with inhalation anesthesia had always a singular fascination for the student. How does the anesthetic act? How is a sleeplike condition with suspension of all sensory transmission procured? While the rhythmic sleep particular to the whole animal and vegetable kingdom has no special chemico-physiology, but is rather the result of habit, in anesthe-

sia however we have to deal with a more specific phenomenon, the analysis of which has not come so far within the grasp of the experimenter.

The anesthesia considered in this paper to a certain extent is similar to the narcosis by the so-called narcotics, similar to the artificial cerebral anemia and similar to the saturation of the blood with magnesia salts. The narcotics can be fatal when used in overdose, so the cerebral anemia when prolonged magnesia when used more than 115 g. to the kilo of the animal. Anesthesia as used for surgical operations is not sleep, it is a condition beyond sleep. Sleep does not suspend all reflexes; surgery needs such suspension as far as sensation of pain is concerned. Sensation and pain both require for their perception a certain condition of the cerebral centers and of the sensory nerves and the spinal cord, by which impression are carried to those centers. By the inhalation of chloroform and ether we produce a suspension of these transmissions by gradual abolishment of all reflexes. First the foot and patellar reflexes, then skin reflexes, then conjunctival reflex and lastly nasal reflexes, and these reflexes are restored in the inverted order. Ether differs in so far as the patellar reflex is increased at first.

Based upon the gradual abolishment of the reflexes we can recognize four distinct stages of anesthesia which correspond to four corresponding actions of the anesthetic, namely: stimulant, narcotic, anesthetic and paralytic.

The stimulant action induces the first stage, the stage of excitement, more so in ether than chloroform, but present with all members of the alcohol series. Respiration and circulation become accelerated and the mental equilibrium is disturbed. This is followed by the narcotic stage in which sleeplike condition is produced by abolishing the trans-

mission to the higher centers, while the lower react yet. In this stage, minor surgery, dental and obstretical operations can be performed and spasms relieved.

In the third stage, the true anesthetic, all reflexes from without are suspended. Going beyond this stage we reach the fourth in which the centers are paralyzed, first the respiratory and then the cardiac.

To recapitulate: General anesthesia suspends the sensibility to exterior irritation by affecting directly or indirectly the nerve centers. The solution is to be found in a bio-chemic process which arrests the processes of metabolism in the nerve cell, which is necessary for their functional activity. We know that the members of the alcoholic series change the fat and water structure of the finer ganglion, and in this relative affinity for fats and water is to be read the coefficient of the narcotic power of a given substance. But before the more intimate problem as to the mode of molecular disturbance that takes place in this partition in the lipoids of the nervous system, physiology is dumb. So much is certain, we have not only a change in the chemic structure by altering the molecular composition of some constituent, but also in blood supply, but either whether this leads to prevention of the generation of nerve force or only interferes with their manifestation, is unknown. Furthermore we do not know how far to consider a modification in the circulation of the nerve centers or a change in the composition of the blood itself so much as to make it unfit for the proper nutrition of these highly complex structures.

The untoward symptoms, especially of chloroform, have their physiologic explanation often outside of the nerve system. Chloroform is a protoplasmic poison to the muscle fibres, and hereby

the question of heart failure and organic degeneration is partly solved. On the other hand, chloroform is a blood-poison, it destroys the red corpuscles. In the lungs the corpuscles are not long enough exposed to suffer material changes, but as soon as the drug is pushed and the whole circulation is so saturated as to have free chloroform present, the destruction becomes rapid. The hemoglobin also is decomposed. Hemoglobin has more affinity for carbon oxide than for oxygen, and absence of the latter or saturation with the first must lead to a decomposition and in consequence to degeneration of those organs which depend on the normal condition of the same.

MEDICAL RECIPROCITY.*

Editor Medical World: Prior to 1902 medical reciprocity, while a popular and interesting subject, was in effect simply a theory, and nothing practical had been done toward even its partial adoption in any of the States.

In the winter of 1902 the American Confederation of Reciprocating, Examining and Licensing Medical Boards was founded, with a membership of three boards, namely: Wisconsin, Indiana, and Michigan. The Confederation adopted the following qualifications as a basis for reciprocity:

Qualification No. 1.

That a certificate of registration showing that an examination has been made by the proper board of any state, on which an average grade of not less than 75 per cent was awarded, the holder thereof having been at the time of said examination the legal possessor of a diploma from a medical college in good standing in the state where reciprocal registration is sought, may be accepted, in lieu of examination, as evidence of qualification. Provided, that in case the scope of the said examination was less than that prescribed by the state in which registration is sought, the applicant may be required to submit to a supplemental examina-

tion by the board thereof in such subjects as have not been covered.

Qualification No. 2.

That a certificate of registration, or license issued by the proper board of any state, may be accepted as evidence of qualification for reciprocal registration in any other state. Provided, the holder of such certificate had been engaged in the reputable practice of medicine in such state at least one year; and also provided, that the holder thereof was, at the time of such registration, the legal possessor of a diploma issued by a medical college in good standing in the state in which reciprocal registration is sought, and that the date of such diploma was prior to the legal requirement of the examination test in such state.

At the present date the following States are actively engaged in endorsing each other's licenses through reciprocity, either upon the basis of Qualification No. 1 or upon the basis of Qualifications Nos. 1 and 2: Wisconsin, Indiana, Iowa, Maryland, Kansas, Nebraska, Minnesota, Wyoming, North Dakota, Missouri, Nevada, Ohio, Illinois, Maine, New Jersey, Georgia, South Carolina, Vermont, Texas, Michigan, Virginia.

Of the above twenty-one states, sixteen reciprocate under both qualifications. There are two classes of practitioners affected by medical reciprocity, viz.:

First: Recent graduates of medical colleges who have obtained their state license through the qualification of a state board examination (Qualification No. 1).

Second: Older graduates of medical colleges who obtained their State license through the qualification of registration upon the basis only of their

recognized medical diplomas prior to the date of the double State qualification of diploma and board examination (Qualification No. 2).

Practicians under Qualification No. 1 at the present time approximately form 10 per cent. of the total of practitioners, while those practitioners under Qualification No. 2 form nearly 90 per cent.; and in this class will be found also at least 90 per cent. of the experienced and notable men in the profession, the professors and teachers in medical colleges and members of state medical boards.

A measure of reciprocity, then, that includes simply those members of the profession in Class 1, the recent and inexperienced practitioners whose claims for consideration through reciprocity are subject to a great deal of discount owing to their recent graduation, and which excludes 90 per cent. of those practitioners to whom reciprocity is really a deserving and relieving measure, seems to me to be unworthy the consideration of intelligent and self-respecting members of the profession. Consequently it does not seem an equitable or legal measure for a State medical board to commit itself to the policy of recognizing for inter-State exchange certificates of registration or licenses obtained solely upon the basis of a State board examination.

Boards who adopt this policy in reciprocity of an absolute requirement of a State board medical examination, create a legal distinction between an examination conducted by a State medical board and an examination conducted by an authorized and reputable medical college, both examinations covering the same ground.

Previous to the establishment of a State examination the law recognized for license the examination made by a reputable medical college. It should, therefore, follow that a college exami-

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nation, up to the date of the enactment of a State examination law, would be held as equal in law to the latter if retroactive legislation is to be avoided. This phase of the question is covered by an act of Congress passed last January, applicable to medical reciprocity in the district of Columbia, as follows:

The board is authorized to issue an endorsement of a license of another state if the applicant acquired the right to practice medicine and surgery in such jurisdiction under conditions equivalent to those with which he would have had to comply in order then to have practiced medicine and surgery in the District of Columbia.

This act of Congress recognized, therefore, as an equal qualification with that of a State board examination an examination made by a reputable and recognized college, up to the date when the former became a legal requirement in the State.

The principles of law involved in the above are becoming gradually recognized among the greater majority of the better States, and as a sequence of such recognition these States reciprocate under both qualifications of the American Confederation. There are States, however, whose law seemingly specifically requires in reciprocity the absolute requirements only of Qualification No. 1. Examples of such States are Ohio and Illinois. California, in addition to the requirements of Qualification No. 1, requires that the "legal requirements of the State at the date of the license should in no degree or particular be less than those of California at the time that such certificate shall be presented for registration to the latter board."

Acts of this nature create a favored class of practitioners, from the fact that a licentiate in California whose qualifications are such this year that he is able to go to other States in reciprocity will be subject to the loss of his status in the event of even a very slight raise in the California standard, as the State in re-

ciprocity would also be obliged to require the increased standard. This same principle of an inequitable law would also apply to those States which recognize as a qualification for reciprocity the provisions only in Qualification No. 1. The reputable and well-qualified practitioner of several years ago, in obtaining his State license complied with all the legal requirements at that time. He could not have been expected in law to pass a State board examination when the provision for such examination did not exist, nor was it possible in his course in college for him to attend a certain number of hours upon the subject of bacteriology when no such course was given in the college.

It follows, then, that every time the standards of such States are increased, a certain percentage of the legal practitioners in such States are disfranchised in the matter of medical reciprocity. Unquestionably this is not only an injustice, but also it would seem to be illegal, from the fact that through the executive of the State, qualifications legally acquired are being taken away without due process of law.

Of course it was to have been expected that the obstacles and hindrances to reciprocity of the nature quoted above should arise, from the fact that every State in the Union, under its police power, has had authority to regulate the practice of medicine in a manner thought best by its legislature; and it was not expected, or perhaps even possible, under the circumstances, for medical acts to be either uniform in their requirements, or that these requirements should in every case be in harmony with constitutional law. Undoubtedly time and proper knowledge of the defects will remedy the matter. The fact that some twenty of the better States have been able to adopt a broad and liberal measure of reciprocity within a period of some three years is ample

evidence of not only the popularity of the question of medical reciprocity, but is also evidence of its absolute necessity to the medical profession as an economic measure.

There are other hindrances to medical reciprocity which might be cited, and which time, patience and good nature only will overcome. Among those hindrances might be quoted the position of the New York Board of Regents on the subject. It announces its belief in reciprocity and admits its legal ability to reciprocate with other States, but gives as a reason for not doing so that the requirements of no other State in the Union are equal to the requirements of New York. A critical examination of the New York standard of preliminary and medical education demonstrates the fact that several of the reciprocating States above enumerated have very much higher requirements, and while this difference can be demonstrated as easily as it is possible to demonstrate that two plus four more than equals two plus two, New York insists that the New York two plus two more than equals the two plus four of other States.

And what is true of New York is equally true of some of the other eastern States.

However, as a hopeful sign, New York has recently admitted, in a half-hearted sort of way, that possibly she might be able to add correctly if approached in the proper spirit.

Another obstacle met with in medical reciprocity is the unique and ludicrous position of a board which advocates reciprocity upon the lines advocated by the Colorado board. From the fact that the Colorado medical law demands as a requirement for registration: (1) a recognized diploma, or (2) a State board examination, it will be readily seen that any practitioner who has a recognized diploma and a moral character

can register in Colorado. The minimum requirement in reciprocity is (1) a recognized diploma, and in addition, (2) a state board license; therefore the additional qualification of a state license is unnecessary in order to comply with the Colorado requirements, and reciprocity is not a material question or necessary as far as laws similar to that of Colorado are concerned, for she demands simply a portion only of the minimum of reciprocity requirements. Certainly reciprocity under Qualification No. 2 would benefit a large percentage of licentiates of Colorado, but it would not be a material or legitimate reciprocity as far as the interests of other States are concerned, but rather would be an "inequitable restriction."

Still another obstacle might be mentioned: that of the quality of support given to reciprocity by medical societies or associations. These associations which represent secular medicine are usually narrow and prejudiced and without the necessary knowledge, experience and authority, and often attempt to usurp the authority of the several boards. As an example, the Reciprocity Committee of the A. M. A. might be quoted. Its membership is composed of those who either have no official position or opportunity to be effective in the cause, or those who, having had the position and opportunity to be useful, have proved themselves absolutely incompetent. The present chairman is known chiefly through the impossible and ridiculous reciprocity schemes he has fathered, and only recently he wrote to the members of his committee that "with nearly fifty States of different standards, reciprocity based upon equity seems to me neither attainable nor desirable." Another prominent member of the committee advocates a committee of members of the A. M. A., whose duty should be to instruct members of State

medical boards in their official duties, and who writes of "Reciprocity with a big R," and that "will o' the wisp—medical reciprocity." With a committee membership made up of members of a quality such as quoted, is it strange that the Committee on Reciprocity, A. M. A., is regarded by those who are doing practical work in this field as a possible obstacle and hindrance to the cause of reciprocity?

B. D. HARISON.

Sault Ste. Marie, Mich.

INTERSTATE RECIPROCITY.

George W. Webster, M.D.

President Illinois State Board of Health;
Secretary Council on Medical Education of
the American Medical Association, Chicago.

In considering the question of interstate reciprocity in medical licensure we are confronted by several fundamental facts, a want of knowledge of which is at the foundation of most of the present nebulous, hazy, chaotic ideas in regard to this subject. These are the facts:

First—Everything relating to the whole subject of medical education, including preliminary entrance requirements, the license and control of the practice of medicine, belongs to the state; its regulation and control is an exercise of the general "police power" of the state; it is one of the state's rights with which the federal government has nothing whatever to do.

Second—The State Board of Health, or the examining or licensing board in each state, is, in view of the authority vested in it by the legislature, the only body authorized to determine the condition or terms under which physicians are licensed to practice in that state. This body determines the character of the entrance requirements, the length and character of the medical course, the subjects embraced in the medical curriculum, the time to be devoted to each,

the character and scope of the examination, the equipment of the medical college in order to be in "good standing" with the board. The state alone, each for itself, through its examining board, has the sole right to establish and to maintain medical educational standards.

Third—These laws and rules are not made and executed and standards maintained in the interests of the medical profession, but for the protection of the people, it being an inherent, constitutional right with which they are guaranteed—the right to "life, liberty and the pursuit of happiness." This fundamental fact is almost universally overlooked, both by the medical profession and, more especially, by those seeking special legislation in favor of special sects, such as osteopaths and the like.

Fourth—In accordance with its recognized constitutional right, each state has established its own standards, there being no uniformity between them, or at least there was formerly none, but at the present time there is comparative uniformity among some of them.

Fifth—Each of the 157 medical colleges in the United States has adopted a standard of its own for conferring the degree of M.D., but this does not confer the right to practice, as this would be delegating the authority of the state to the medical college.

Sixth—That various associations of medical colleges, state boards, etc., have established standards, but they also have no right to determine and to enforce standards for any state, as this would be delegating the power of the state to some organization, and this would not be tolerated.

Under these circumstances, what can be done to bring about exchange of licenses on a fair and equitable basis. A fair exchange can be made only on equal terms. Let us see what has been

accomplished. Take Illinois for example. Illinois has determined that an applicant for licensure must have, as a preliminary entrance requirement, a high-school education or its equivalent, must have attended four courses of instruction of not less than seven months each in four separate calendar years in a medical college, the character and equipment of which is determined by the board, must have received a diploma after graduation from said institution and must have also sustained a satisfactory examination in all the branches usually embraced in the medical curriculum, the number of questions in each subject corresponding to its time value in the curriculum. Illinois offers to reciprocate with any state having equal requirements. On this basis Illinois at the present time does reciprocate with the following states: Iowa, Michigan, Wisconsin, Indiana, New Jersey, Maryland, Maine and Kansas.

In other words, here is practical reciprocity on the only rational basis: equal requirements, uniformity in entrance requirements, uniformity in length and character of the medical course and uniformity in the scope and character of the examinations. Uniformity in legislation is also desirable.

How can this scheme of reciprocity be extended so as to embrace all or nearly all the states? I would propose the following:

It should be done through the organized profession, as embodied in the American Medical Association and by its Council on Medical Education. This council should appoint the following committees:

First—A subcommittee on entrance requirements, comprised of, say, ten members, representing the medical colleges, the universities, the high schools and the boards of examiners. Let this committee be given at least a year, or,

if necessary, a longer time, to study the whole subject and then to report to the Council on Medical Education what the minimum entrance requirements should be.

Second—A subcommittee of five or ten members for each of the twenty-three subjects in the curriculum, the committee to be selected from the leading educators in each subject and including, if possible, members of examining boards on each sub-committee. Let each of these committees establish a minimum standard and determine how many hours should be devoted to the subject, how much of this time to lectures, to recitations, to laboratory work and to clinics, and what kind of equipment, teachers, etc., are required to teach the subject properly, and the order in which the subject should be taught in relation to other subjects.

Third—An additional committee to determine whether other subjects, such as business methods, history of medicine, etc., shall be added to the present curriculum, and, if so, how much time should be devoted to them and where in the course they should be placed.

The committees, aggregating, in round numbers, 250 of the leading medical educators of the United States, would report to the educational council and it in turn would codify the work, and thus would be established standards of such high order of merit that no one would be able to criticise it successfully. The council would also provide for a plan of regular periodical, perhaps decennial, revision of this standard. Each state and medical society adopting this standard would be entitled to representation in the revision convention.

Then let the council urge the legislative committee of the American Medical Association to work in the interests of uniformity in medical legisla-

tion for the states through the legislative committees and examining boards of all the states.

To establish reciprocity it is only necessary for the states to adopt the standards of the Council on Education. As soon as a medical college adopts this standard let it be enrolled as an institution in "good standing," both with the council and with all examining boards that have adopted this standard. As soon as two states have adopted this standard there is reciprocity on a fair, rational, equitable basis. In a very short time a large number of states and the leading medical colleges will have adopted this standard and the others will be gradually brought up to it.

ADVANTAGES OF THE PLAN.

The advantages of this plan are:

1 It secures the co-operation of the American Medical Association and of the medical colleges.

2 It secures the co-operation of the high schools, the medical colleges, the universities and the state licensing boards in the establishment of standard requirements for entrance to the medical colleges.

3 The proposed standards will be more likely to be adopted because all parties concerned in their adoption are participants in their preparation and establishment.

4. It will bring the American Medical Association and the licensing boards into closer and more harmonious relationship.

5 It will bring the American Medical Association and the Medical Colleges into closer and more harmonious relationship.

6 It not only provides for high, reasonable and uniform standards for the present, but it provides for regular periodical revision by those adopting it

and, therefore, interested in its maintenance and perpetuation.

7 It will bring into co-operative harmony the legislative committee of the American Medical Association and the legislative committees of the states.

8 After definite, uniform standards are adopted, it will be easier to secure the enactment of uniform, favorable, desirable legislation.

9 It establishes interstate reciprocity on a reasonable basis.

BOOK REVIEW.

Diseases of Infancy and Childhood—
by L. Emmett Holt, M.D., Sc. D., LL.D.
D. Appleton & Co., Pub. Cloth \$6.00.

Third edition, revised and enlarged by this well known author. This standard text book has now passed its fiftieth thousand, a most remarkable showing for a book upon this subject.

Many chapters in this edition have been enlarged, and others, especially upon Examination of Sick Child, Hypertrophic Stenosis of Pylorus, Diarrhoeal Diseases and Dysentery, Vaginitis, Cerebro-Spinal Meningitis, Mental Defects, Chondro-Dystrophy, Status Lymphaticus, and Diphtheria have been entirely rewritten, some chapters appearing for the first time.

The author appreciating the value of good illustrations, has taken advantage of the opportunity and added many new ones, and a number of the old illustrations have been replaced by better ones.

A New Disease.

"Good morning, Aunt Fannie, they tell me Charlie is dead."

"Yes, chile, he's dead and bur'd in de commissary."

"What was the matter with him?"

"I doan' know; I warn't thar, but they tells me he was tucken with a streak ob moralis. —Dr. J. Dabney Palmer.

NEW MEXICO MEDICAL ASSOCIATION NOTES OF INTEREST.

Owing to a conflict in dates or various meetings, the Council has changed the date of the coming meeting of the New Mexico Medical Association from May 9th to May 2nd. Members will please note this and govern themselves accordingly.

* *

There was a called meeting of the Council held in Albuquerque on February 15th, when business of some importance to the Association was transacted.

* *

The Secretary will be pleased to have the members mail the titles of their papers to be presented at the coming meeting. He is anxious to have a good program, and the sooner the titles are sent to him the better.

* *

The Secretary desires to again call the attention of the profession of the Territory, regardless of affiliation with the Territorial Association, to the permanent record blanks. It is of more than passing importance that these blanks be filled out and mailed to him at once. If there are any practitioners who have not been furnished with a blank, they have only to write to the Secretary and these will be sent to them.

* *

The Secretary has been instructed by the Council to issue a cordial invitation to all practitioners of the Territory who are *regulars*, to be present at the next meeting of the Territorial Association and take part in the scientific program. Any papers that may be presented by these invited guests will be gladly received and discussed. The Secretary hereby issues the invitation.—ALBUQUERQUE, MAY 2, 1900. A full attendance is urged.

Not Satisfactory.

Sandy was considerably run down, and submitted his case to the M. D. After a diagnosis, the physician said: "No red meat, no whiskey, and only one pipe a day." Sandy grunted, put on his bonnet and started out. "Wait," said the doctor. "You've forgotten something." "Fat micht that be?" asked Sandy. "My fee," was the reply. "Fee? Fat for?" asked Sandy. "My advice." Hoot, mon," said Sandy, "A'll no be takin' yer domned advice!" and he stalked out of the room.—*Controller Grout in N. Y. Globe.*

Had a "Bargain Mother."

The arrival of twins to her mother was told to Ethel, the ten-year-old daughter.

"Oh, dear," said the little girl, "mamma has been getting bargains again."

An Office Call.

Teacher — Tommy, something has got to be done about your behavior. I think today after school I shall call and see your father.

Tommy—It'll cost you \$2 if you do. Pop's a doctor; office hours, 5 to 7.—Puck.

Greatest of the Great.

She (at the piano)—Who, in your estimation, is the greatest living composer.

He—I can't recall his name, just now, but he manufactures a popular brand of soothing syrup.—*Chicago News.*

Made to Order.

A small girl was taken violently ill from an over-indulgence in unripe fruit. Her mother telephoned for the nearest doctor, whose telephone number proved to be surprisingly appropriate to the occasion, "eighty-one-two-Green."—*Lippincott's Magazine.*

TUBERCULOSIS AND PATENT MEDICINES.

G. R. Pogue, Denver (*Journal A. M. A.*, March 3), thinks that our therapeutic nihilism and teaching that only outdoor treatment is effective for tuberculosis, has had a bad effect and has driven many victims of the disease, to the use of proprietary remedies that immodestly and incorrectly advertise their alleged efficacy. He was recently told by a prominent pharmacist that while the sale of patent medicines had notably fallen off, he still sold large quantities of certain of them to consumptives. Climatic resorts to which consumptives flock are a bonanza for the advertising quack and patent medicine vendor whose stock argument is that physicians admittedly have no cure for the disease as compared with their unfailing panaceas. The poor consumptives are only too ready to grasp at any straw, hence they fall readily into the hands of these quacks. Our therapeutic nihilists, as regards consumption, could do better. Pogue thinks, if they would turn their talents in some other direction when they write for the information of the laity.

ALBUMOSURIA IN PHTHISIS.

J. F. McConnell, Colorado Springs, Colo. (*Journal A. M. A.*, December 16), says that in making a series of urinalyses for the purpose of computing the prognostic value of Ehrlich's reaction in the tuberculosis, his attention was directed to the large proportion of the specimens giving a precipitate with the characteristics of an albumose. Finding little in the literature concerning the significance of this substance in the urine in tuberculosis, he has further studied the matter and offers as a result a clinical deduction which he considers to be of importance as putting the empiric therapeutic theory

of rest in this disease on a rational basis. He found that febrile cases giving a positive albumose reaction in the urine were not improved by exercise, but rather lost ground, while those giving no albumose reaction were injured by the rest treatment and decidedly benefited by regulated exercise. Details are given of the test employed for the detection of albumose in the urine, and illustrative cases are reported.

UTERINE MYOMATA AND MALIGNANT DISEASE.

T. S. Cullen, Baltimore (*Journal A. M. A.*, March 10), calls attention to the danger of incomplete examinations after hysteromyomectomy as regards the possible existence of malignant disease. He has been surprised to find how frequently myoma is associated with carcinoma in the large experience at the Johns Hopkins Hospital, and in 1903 he advised opening the uterus immediately on its removal to ascertain whether or not any chance carcinoma of the uterine body existed, and he now recommends not only the careful examination of the uterine cavity, but also of the myomatous nodules. As an illustration of this, he reports a case of supravaginal hysterectomy supposedly for simple interstitial and subperitoneal myomata. Two years later sudden collapse occurred due to hemorrhage from sarcoma of the cervical stump. Re-examination of the original tumor showed typical sarcomatous changes of the myoma. The patient died eight months after a second laparotomy and about two months after the progress of the growth had necessitated an operation for obstruction of the bowels. The case, he says, clearly indicates that physicians should examine carefully, not only the uterine cavity but also the myomata before the cervical stump is closed.

THE NOSTRUM EVIL.

F. Billings, Chicago (*Journal A. M. A.*, March 10), blames the medical profession primarily for the extensive use of nostrums; if there were no demand there would be no supply. Too many physicians are careless in studying the treatment of their cases and accept too readily the claims of nostrum makers for the therapeutic value of their wares. The often deceptive nomenclature of copyright drugs and ridiculous claims made regarding their therapeutic virtues are all noticed and striking examples quoted. The fault of the medical journals in lending their advertising pages to the exploiters of these preparations is also pointed out and how the evil habit of using these remedies has grown by this means in the medical profession. To correct the evil the medical schools must teach the student more fully and adequately the principles and details of botany, pharmacology and therapeutics, the medical journals must cease their indiscriminate advertising of proprietary drugs. The exhibition of pyramids of nostrums must not be permitted at society meetings and publicity should be given to their undesirableness and danger both to the profession and to the public generally. The pharmacopeia, Billings states, contains all that is really necessary and gives it at its true value.

THE PATENT MEDICINE AND NOSTRUM EVIL.

Referring first to the recent efforts in several quarters to check the patent medicine frauds, J. M. Anders, Philadelphia (*Journal A. M. A.*, January 27), shows up the nature of the business and the unfortunate aspects of its success. While it would be unjust to condemn all proprietary remedies indiscriminately, he states that a great

majority of those before the public are clearly condemnable because of their secrecy and their dishonest exploitation. It is a great misfortune that they have so far subsidized a considerable portion of the medical press of the country and also that of late years the medical schools have not fully realized their responsibility in this matter. The teaching of the art and science of pharmacy has not received the attention it deserves. Anders points out the ways to combat the present evil, referring especially to the work of the Council on Pharmacy and Chemistry of the American Medical Association, and the praiseworthy work being done by certain secular journals at the present time. In his opinion, legal enactments compelling, under penalty, the printing of the formula on the bottle or package and proper labeling of poisons would be a very effective measure, and the opposition of the patent medicine manufacturers to such an enactment is strong evidence of this. He submits a series of propositions of the lines of attack against the evil, including agitation through high class and other medical journals for the enlightenment of the public, better education of medical students in pharmacy, co-operative work like that being done in the Council on Chemistry and Pharmacy, continued exposure of patent medicine and nostrum methods and disclosures of the composition of these preparations; the creation of a profession sentiment to the effect that trade-marked nostrums are unworthy of being prescribed; attempts to emancipate the medical and lay press; enactment of appropriate legislation; and the completion of the organization of the medical profession in America, in accordance with the plan proposed by the American Medical Association in 1900.

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(Denver Times)

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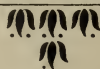
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